

# OVERVIEW OF FAMILY CARE RESOURCE ALLOCATION DECISION (RAD) METHOD

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RAD Method developed for Family Care Care Management Organizations (CMOs) to do:

## **Person-centered** case management

By TEAM: member, social service coordinator (SW) and RN, and  
also: family, direct care workers, therapist, MD, etc. as person desires  
Sharing power (member & staff; professionals & non-professionals; RNs and SWs)  
Sharing responsibility  
Sharing ideas: respecting different perspectives to find creative options

## **HOW DOES TEAM DECIDE SERVICES?**

Comprehensive **Assessment**

Person's needs, strengths, resources, and preferences

Identify individualized outcomes (within framework of Family Care outcomes)

Using Family Care "Resource Allocation Decision Method"

**THE RESOURCE ALLOCATION DECISION METHOD is intended to answer the question:**

***IS PERSON-CENTERED MANAGED L.T. CARE REALLY POSSIBLE?***

**THE "STANDARD" CONFLICT IS BETWEEN  
THE PROVIDERS' FINANCIAL INTERESTS  
AND  
CONSUMERS' SERVICE NEEDS (let alone preferences!)**

**This dichotomy does not work well:**

Encourages under-serving.

Too heavy a burden for LTC Case Managers (who feel conflicted between consumer and agency)

Sets agency supervisors (agency fiscal worries) against case managers (trying to serve people)

**Previous Attempt to move beyond this dichotomy:**

1. Require providers to meet generic/ aggregate minimum standards  
Limitations: Minimums may be too much or too little for an individual consumer  
Not every circumstance can be anticipated to set minimum

2. Demand OUTCOMES: This creates new dichotomy between fiscal incentive to under-serve and accountability (penalties) for outcomes

Limitations: Individual outcomes (& abuses) can be lost in aggregate data  
Regulatory agencies are slow to respond to aggregate data reports  
Penalties for poor outcomes can fail to deter provider  
Data reporting can be manipulated, and can be misleading

**Beyond aggregate outcomes:**

**Demand CONSUMER OUTCOMES and PERSON-CENTERED services**

This creates a new dichotomy between

FISCAL INCENTIVE TO UNDER-SERVE

AND

INDIVIDUAL'S OUTCOMES AND PREFERENCES

PERSON-CENTERED decisions require detailed info about the person and her/his circumstances, preferences, individual outcomes.

Upper management is not likely to know all that info.

Next step to reduce errors and burden upon case managers:

Replace Agency Solvency Motive with

A more manageable common-sense question of cost-effectiveness for everyone to use:

**“What’s the most cost-effective way to meet this person’s individual outcomes?”**

**Result:**

**Those who know the consumer best work with the consumer**

**To find the most cost-effective way to meet individual outcomes.**

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**ONE COMMON-SENSE AND COMPLEX QUESTION:**

**“What’s the most cost-effective way to meet this individual’s outcomes?”**

Team staff always remain committed to helping the person meet her/his outcomes

—even when suggesting more cost-effective ways to meet individual’s outcomes.

Saying “Yes” is done with the same method as saying “No.”

Actually, it’s not team staff deciding “yes” or “no” - - it’s saying “Instead,” and exploring options with the person, negotiating, trying things short-term.

All decisions, large & small, are made with same method, not just “expensive cases.”

## UNPACKING THE QUESTION

**“What’s the most cost-effective way to meet the individual outcomes?”**

### **1. Identify individual outcomes: ALWAYS THE FIRST, FIRST, FIRST STEP!**

This requires knowing the person, their preferences, values, history

Can be very complex: It IS best case management practice:

Quality of life issues, psychological & emotional issues

It’s not about “stuff”! Never focus only on things or services:

Look deeper than request, **ask WHY. Keep asking “Why?” to find individual outcomes**

### **2. Check effectiveness:** Would suggested or requested option be **effective** in meeting individual outcomes?

How will you tell? When?

If you have no way of knowing, you might decide not to cover it because it doesn’t meet your criterion for effectiveness. (This is a reasonable criterion that does not in itself constitute a bias against non-traditional “alternative” or “complementary” therapies.)

### **3. Explore cost-effective options** to meet the individual outcomes.

Creativity requires multiple perspectives.

Negotiate with person.

Try things short-term.

### **Results: “Cost-effective” does not mean “least expensive”!**

Decisions **MUST** be grounded in the individual outcomes and circumstances

It is **NOT** about comparing one standard service against another:

Always go back to what would effectively meet the individual’s outcomes

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## **Agency Management Has New Role:**

- ◆ To empower case managers to find the most cost-effective ways to meet individual outcomes.
- ◆ To help case managers do this with consistent process: i.e., do on-going quality assurance and quality improvement:
  - ◆ Ensure consistent decisions over time and across staff and cases
  - ◆ Facilitate discussions/ meetings as necessary
  - ◆ Foster “brainstorming” on more cost-effective ways to meet individual’s outcomes
  - ◆ Foster development of new provider and community resources
- ◆ To not make decisions based on old dichotomies or hierarchies

Other mechanisms to help:

### **Build in TOTAL QUALITY IMPROVEMENT approach**

Input from all levels to identify problems and seek solutions

Build in CONSUMER input at all levels

Because you can’t have creativity if trying to hide problems

This plus person-centered, creative approach helps with staff retention

## ASSUMPTIONS OF R.A.D. METHOD:

- ◆ Cost-efficiency is built into every decision, not just large ones
- ◆ Stimulating creativity to always seek more cost-effective options
- ◆ Resultant savings will be significant enough to pay for:
  - Additional case management time for person-centered planning and exploring more options
  - Additional quality assurance roles for supervisors
  - Possibly more services for more people as savings accrue
- ◆ Cost-efficiency presented so reasonably that even members, families, advocates agree to it
- ◆ Gets consumers' "buy-in" and demystifies decision process to reduce power struggles

## OTHER CURRENT APPROACHES THAT ARE NOT HELPFUL:

### 1. Entitlement to particular services

- ◆ Can be wasteful if services are not really needed by individual or more cost effective options would work as well or better
- ◆ In Family Care, eligibles are entitled to the benefit, and entitled to the consumer outcomes (required by DHFS contract with CMO), but CMO has flexibility in particular services to attain those outcomes for that individual

### 2. "Need vs. want" distinction

- ◆ "Need vs. want" is a judgment professionals make subjectively. It gets misused very often and tends to carry hidden judgments/assumptions.
- ◆ Conflicts with Family Care goal of maximizing consumer preferences  
(e.g., I need a bath, I want my daughter to do it instead of some stranger)
- ◆ Like Maslow's pyramid of need, implies that health and safety "counts more" than quality of life; would "overmedicalize" the program and deny consumer choices

### 3. Calling all resource allocation decisions "ethical dilemmas"

- ◆ Removes a major part of social work & nursing practice to realm of "ethics experts"
- ◆ Disempowers social workers and nurses for whom ethics has been mystified
- ◆ Every decision, large and small, should be cost-effective in meeting outcomes; ethics committee can't handle day-to-day decisions (and doesn't have enough detailed knowledge or relationship with consumer to do so)
- ◆ Not all decisions involve conflicts in values

### 4. Mistakes with justice/ fairness criterion:

- ◆ Justice (as in fair distribution of scarce resources) is too broad, easily misused.
- ◆ Can include social biases and resentment (notions of the "undeserving poor," or of "My HMO won't give me what these clients get...")
- ◆ Justice/fairness is usually impersonal, misconstrued as "Treat everyone the same."
- ◆ Programs/ agencies can be **person-centered and fair** if like treated alike  
"Like" in all complexities of circumstances, preferences, quality of life & emotional issues, - - NOT just similar labels or diagnoses!
- ◆ **Members:** "You bought her one, you have to buy me one."

- ◆ **Staff:** “We can’t do weekends, we’ll go broke, and that wouldn’t be fair to others who need our program.”

Other confusion: using fairness to justify unfounded traditions/ habits:

“We’ve never done it before, so it’d be unfair to do it now.”

### 5. The “gatekeeper” versus “advocate” dichotomy

- ◆ Dominant theme in bioethics literature on managed care (especially re MD’s)
- ◆ Resource allocation should be done by disengaged (but not disinterested) parties
- ◆ This dichotomy does not fit long term care social services
  - ◆ Bias toward impersonal model (“objective,” rational/science models)
  - ◆ Violates person-centered approach
  - ◆ Internalizing this conflict only increases staff’s burden

### 6. The Advocate Model:

- ◆ Case manager’s job is to fight the system, to find funding to get person help
- ◆ Saying “No” is avoided or is blamed on outside forces (system rules or payer denials)
- ◆ With RAD Method, case managers will say “No,” or at least “Instead,” and still be in relationship with consumer, still be committed to advocating for their individual outcomes.
- ◆ With RAD Method, **reasonable people can disagree**, and that’s okay. Member can grieve or appeal, and that needs to be okay, continue relationships.
- ◆ Social workers’ advocacy is not the same as nurses’ advocacy: Person-centered services require they work together to create quality from consumer’s perspective

In Summary: See RAD Method document itself. Additional diagram:

